Patient _____ Date of Birth_____

HIPAA Privacy Information

In order to comply with federal regulations regarding you privacy in our office, we ask that you complete the following questions:

May we leave appointment messages or other medical information on/with:

Your answering machine? ___Yes ___No

Office voice mail? ___Yes ___No

With another person? ___Yes ___No

Through the mail? ___Yes ___No

Via email? ___Yes ___No

Cell phone? ___Yes ___No

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list the following information:
(**Please include anyone that may bring your child to an appointment.**)

Contacts/Parents	Relationship	Phone	Cell
1_____	_____	_____	_____
2_____	_____	_____	_____
3_____	_____	_____	_____
4_____	_____	_____	_____
5_____	_____	_____	_____
6_____	_____	_____	_____

_____ _____

Signature Required of Patient or Patient Representative Date

_____ _____

Printed Name of Patients Representative Relationship to Patient